FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041269

Facility Name: Lemont Center

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

IDPA ID Number: 22-3401506001

Date of Initial License for Current Owners: 2/24/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Skander Nasser, III **Telephone Number:** (317) 237-5500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Debbie McLarty

(Title) VP of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Skander Nasser, III - Partner

(Firm Name & Address) Bradley & Associates, 201 S. Capitol Ave, #910
Indianapolis, IN 46225

(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	124	Intermediate (ICF)	124	45,384	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	255	8	7,521	7,784	8
9	SNF/PED					9
10	ICF	15,683	26,276	166	42,125	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,938	26,284	7,687	49,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.91%

D. How many bed-hold days during this year were paid by Public Aid?
191 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 7,429

Medicare Intermediary RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	255,414	47,744	56,070	359,228		359,228	(4,769)	354,459			1
2	Food Purchase		221,686		221,686		221,686	(5,779)	215,907			2
3	Housekeeping	182,857	30,439	848	214,144		214,144		214,144			3
4	Laundry	46,118	25,761	736	72,615		72,615	(20,828)	51,787			4
5	Heat and Other Utilities			136,708	136,708		136,708		136,708			5
6	Maintenance	56,389	22,207	56,884	135,480		135,480		135,480			6
7	Other (specify):*											7
8	**TOTAL General Services**	540,778	347,837	251,246	1,139,861		1,139,861	(31,376)	1,108,485			8
	B. Health Care and Programs											
9	Medical Director			15,474	15,474		15,474		15,474			9
10	Nursing and Medical Records	2,221,915	69,315	564,166	2,855,396		2,855,396	(4,553)	2,850,843			10
10a	Therapy	2,987	3,142	525,165	531,294		531,294	(16,694)	514,600			10a
11	Activities	135,814	23,265	7,514	166,593		166,593		166,593			11
12	Social Services	105,911	725	1,557	108,193		108,193		108,193			12
13	Nurse Aide Training											13
14	Program Transportation					5,958	5,958		5,958			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,466,627	96,447	1,113,876	3,676,950	5,958	3,682,908	(21,247)	3,661,661			16
	C. General Administration											
17	Administrative	130,451			130,451	(61,822)	68,629	648,846	717,475			17
18	Directors Fees											18
19	Professional Services			13,895	13,895		13,895	(8,764)	5,131			19
20	Dues, Fees, Subscriptions & Promotions			5,041	5,041		5,041	1,340	6,381			20
21	Clerical & General Office Expenses	94,458	24,234	78,853	197,545	61,822	259,367		259,367			21
22	Employee Benefits & Payroll Taxes			649,671	649,671		649,671		649,671			22
23	Inservice Training & Education			103	103		103		103			23
24	Travel and Seminar			8,759	8,759	(5,958)	2,801		2,801			24
25	Other Admin. Staff Transportation			756	756		756		756			25
26	Insurance-Prop.Liab.Malpractice			34,425	34,425		34,425		34,425			26
27	Other (specify):* MISC EXPENSE			99,056	99,056		99,056	(95,943)	3,113			27
28	**TOTAL General Administration**	224,909	24,234	890,559	1,139,702	(5,958)	1,133,744	545,479	1,679,223			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,232,314	468,518	2,255,681	5,956,513		5,956,513	492,856	6,449,369			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Center #0041269 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			335,693	335,693		335,693	743	336,436			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							871,739	871,739			32
33	Real Estate Taxes			258,648	258,648		258,648		258,648			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			42,788	42,788		42,788	(9)	42,779			35
36	Other (specify):*											36
37	**TOTAL Ownership**			637,129	637,129		637,129	872,473	1,509,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			324,651	324,651		324,651	(9,614)	315,037			39
40	Barber and Beauty Shops			36,767	36,767		36,767		36,767			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			443,543	443,543		443,543	(9,614)	433,929			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,232,314	468,518	3,336,353	7,037,185		7,037,185	1,355,715	8,392,900			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,612)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(20,828)	4		8
9	Non-Straightline Depreciation	743	30		9
10	Interest and Other Investment Income	(277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,167)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,581)	27		24
25	Fund Raising, Advertising and Promotional	(13,362)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(7,424)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (129,508)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,485,223		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,485,223		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,355,715		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lemont Center

ID# 0041269

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE LEGAL FEES	$ (8,764)	19	1
2	IL HEALTH CARE DUES	1,940	20	2
3	PAC DUES	(600)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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17				17
18				18
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(7,424)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(4,769)	0	0	0	0	0	0	0	0	0	(4,769)	1
2	Food Purchase	(5,779)	0	0	0	0	0	0	0	0	0	0	(5,779)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(20,828)	0	0	0	0	0	0	0	0	0	0	(20,828)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,607)	(4,769)	0	0	0	0	0	0	0	0	0	(31,376)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(4,553)	0	0	0	0	0	0	0	0	0	(4,553)	10
10a	Therapy	0	(16,694)	0	0	0	0	0	0	0	0	0	(16,694)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(21,247)	0	0	0	0	0	0	0	0	0	(21,247)	16
	C. General Administration													
17	Administrative	0	648,846	0	0	0	0	0	0	0	0	0	648,846	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,764)	0	0	0	0	0	0	0	0	0	0	(8,764)	19
20	Fees, Subscriptions & Promotions	1,340	0	0	0	0	0	0	0	0	0	0	1,340	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(95,943)	0	0	0	0	0	0	0	0	0	0	(95,943)	27
28	**TOTAL General Administration**	(103,367)	648,846	0	0	0	0	0	0	0	0	0	545,479	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(129,974)	622,830	0	0	0	0	0	0	0	0	0	492,856	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	743	0	0	0	0	0	0	0	0	0	0	743	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(277)	872,016	0	0	0	0	0	0	0	0	0	871,739	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(9)	0	0	0	0	0	0	0	0	0	(9)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	466	872,007	0	0	0	0	0	0	0	0	0	872,473	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(9,614)	0	0	0	0	0	0	0	0	0	(9,614)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(9,614)	0	0	0	0	0	0	0	0	0	(9,614)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(129,508)	1,485,223	0	0	0	0	0	0	0	0	0	1,355,715	45

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See attached list		Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10a	Related Party Mark up	$ 16,693	Genesis Rehab		$	$ (16,693)	1
2	V	1	Related Party Mark up	4,331	Genesis Hospitality			(4,331)	2
3	V	32	Interest		Genesis Health Ventures	100.00%	872,016	872,016	3
4	V	17	Administrative		Genesis Health Ventures	100.00%	648,846	648,846	4
5	V	1	Related Party Mark up	438	Neighborcare			(438)	5
6	V	10	Related Party Mark up	4,553	Neighborcare			(4,553)	6
7	V	10a	Related Party Mark up	1	Neighborcare			(1)	7
8	V	35	Related Party Mark up	9	Neighborcare			(9)	8
9	V	39	Related Party Mark up	9,614	Neighborcare			(9,614)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 35,639			$ 1,520,862	$ * 1,485,223	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Facility is owned by a public company								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Genesis Health Ventures, Inc.
Street Address: 101 E. State Street
City / State / Zip Code: Kennett Square, PA 19348
Phone Number: (610) 925-4076
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Costs		58	$ 19,764,727	$		$ 648,846	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 19,764,727	$		$ 648,846	25

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Mellon Bank		x				$ 8,663,841	$ 8,663,841		0.0850	$ 872,016	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,663,841	$ 8,663,841			$ 872,016	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,663,841	$ 8,663,841			$ 872,016	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	100,928	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	266,255	2
3. Under or (over) accrual (line 2 minus line 1).	$	165,327	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	93,321	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	258,648	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	769	8
	1996	110,863	9
	1997	226,113	10
	1998	248,291	11
	1999	266,255	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Use		1994	$ 524,170	1
2					2
3	TOTALS			$ 524,170	3

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1995	$ 7,265,030	$ 215,282		$ 181,626	$ (33,656)	$ 862,596	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Capitalized Interest			1996	99,787	2,482	40	2,494	12	10,645	9
10	Architecture			1997	338	8	40	8		29	10
11	Fire Prevention			1997	495	12	40	12		45	11
12	Temperature Control			1997	4,200	105	40	105		386	12
13	Construction Fees			1997	176,615	4,394	40	4,417	23	15,825	13
14	Plumbing			1997	2,967	74	40	74		246	14
15	Environmental Service			1997	950	24	40	24		80	15
16	Engineering			1997	1,503	37	40	37		123	16
17	Site Lighting for Building			1997	690	20	35	20		65	17
18	Add lighting to Residents Dining Room			1998	1,854	48	35	48		144	18
19	Setting Up Dementia Unit Security System			1998	1,912	45	35	45		135	19
20	Install Counter in Therapy Office			1998	1,720	41	35	41		123	20
21	Water Softener Treatment			1998	1,100	26	35	26		78	21
22	Mixing Valve for Resident Whirlpool Tub			1998	480	11	35	11		33	22
23	Upgrade Multilink Electrical Unit			1998	370	9	35	9		27	23
24	Replace Compressor for Dietary Walk-In			1998	1,649	39	35	39		117	24
25	Upgrade Multilink Electrical Unit			1998	818	19	35	19		57	25
26	Hot Water Tank Replacement Valve			1998	800	17	35	17		51	26
27	Upgrade Multilink Electrical Unit			1998	2,483	48	35	48		144	27
28	Relocate Brass Pipeline & Valve			1998	492	7	35	7		21	28
29	Replace Fire Protection System Pipeline			1998	265	3	35	3		9	29
30	Replace Back Delivery Doors			1998	2,874	13	35	13		39	30
31	Replace Heating & AC Duct Filter			1998	905	17	35	17		51	31
32	Improvements			1999	9,409	269	35	269		538	32
33	Roofing repairs			2000	2,400	69	35	69		69	33
34	Roofing repairs			2000	16,339	467	35	467		467	34
35	Roofing repairs			2000	500	14	35	14		14	35
36	TOTAL (lines 4 thru 35)				$ 7,598,945	$ 223,600		$ 189,979	$ (33,621)	$ 892,157	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 930,697	$ 101,474	$ 142,645	$ 41,171	6-7	$ 639,069	37
38	Current Year Purchases	26,685	3,812	3,812		7	3,812	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 957,382	$ 105,286	$ 146,457	$ 41,171		$ 642,881	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	9,080,497	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	328,886	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	336,436	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	7,550	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,535,038	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 37,880 Description: Nursing $22857, Maint $460, Admin $14563
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Plymouth voyager	$ 409.00	$ 4,908	17
18					18
19					19
20					20
21	TOTAL		$ 409.00	$ 4,908	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	3,982	$	218,994	$	3,982	$ 218,994	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,126		61,917		1,126	61,917	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a, 1-3	119 hrs	2,987	4,441		244,254	3,142	4,560	250,383	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39, 3	# of prescrpts					82,125		82,125	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$ 2,987	9,549	$	525,165	$ 85,267	9,668	$ 613,419	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 423,585	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,096,874		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(4,577)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,515,882	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,420,720		15
16	Equipment, at Historical Cost	969,031		16
17	Accumulated Depreciation (book methods)	(1,505,423)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): other assets	2,980		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,887,308	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,403,190	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 456,251	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,664		30
31	Accrued Taxes Payable (excluding real estate taxes)	275,260		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,321		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab	196,546		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,178,042	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,655,510		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,655,510	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,833,552	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,569,638	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,403,190	$	48

***(See instructions.)**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,342,373	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,342,373	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,227,265	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,227,265	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,569,638	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,117,362	1
2	Discounts and Allowances for all Levels	(1,493,068)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,624,294	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	291,968	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 291,968	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35,552	13
14	Non-Patient Meals	4,612	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	60,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,673	19
20	Radiology and X-Ray	62,934	20
21	Other Medical Services	156,294	21
22	Laundry	20,828	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 347,885	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	277	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 277	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Dental Services**	26	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,264,450	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,139,861	31
32	Health Care	3,676,950	32
33	General Administration	1,139,702	33
	B. Capital Expense		
34	Ownership	637,129	34
	C. Ancillary Expense		
35	Special Cost Centers	361,418	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,037,185	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,227,265	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,227,265	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,822	4,247	$ 116,102	$ 27.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	135,829	150,921	2,105,813	13.95	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist	119	119	2,987	25.10	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,238	12,464	135,814	10.90	10
11	Social Service Workers	6,028	6,584	105,911	16.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,946	28,996	255,414	8.81	15
16	Dishwashers					16
17	Maintenance Workers	3,639	4,028	56,389	14.00	17
18	Housekeepers	19,903	22,708	182,857	8.05	18
19	Laundry	5,663	6,293	46,118	7.33	19
20	Administrator	2,052	2,244	68,629	30.58	20
21	Assistant Administrator					21
22	Other Administrative	11,400	12,464	156,280	12.54	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	226,639	251,068	$ 3,232,314 *	$ 12.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	15,474	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	12,162	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,636		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara Szumski	Administrator	0	$ 68,629
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,629

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sara Szumski	Legal	$ 238
Duane Morris	Legal	2,998
Various	Acct	1,895
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,320
Unemployment Compensation Insurance	64,872
FICA Taxes	241,010
Employee Health Insurance	172,276
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	8,956
Recruiting	20,824
Other Misc	10,413
TOTAL (agree to Schedule V, line 22, col.8)	$ 649,671

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
IL Health Care Dues	4,850
Other Misc	1,530
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,380

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,748
Seminar Expense	1,053
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,801

**See instructions.

LEMONT NURSING & REHABILITATION CENTER
SUPPLEMENTARY SCHEDULE
TRAVEL
SCH XIX - PART G

EMPLOYEE	DATE	PURPOSE	AMT
Sara Szumski	8/25/2000	Fuel for facility van	64
Sara Szumski	9/13/2000	Fuel for facility van	64
Lemont Imprest Acct	9/5/2000	Fuel for facility van	15
Sara Szumski	7/25/2000	Fuel for facility van	64
Sara Szumski	7 - 9/2000	Van Mileage	194
Sara Szumski	10/16/2000	Mileage to divisional mtg in Rockford	94
Sara Szumski	10/11/2000	Mileage to divisional mtg in Wisc Dells	155
Sara Szumski	10/16/2000	Lodging at divisional mtg in Rockford	228
Sara Szumski	10/11/2000	Lodging at divisional mtg in Wisc Dells	216
Deborah Pruim	6/25/2000	Lodging at divisional mtg in Madison	105
Sara Szumski	10/11/2000	Meals at divisional mtg in Wisc Dells	40
Sara Szumski	10/17/2001	Meals at divisional mtg in Rockford	70
Sara Szumski	6/14/2000	"Understanding Dementia" seminar in Chicago	98
		Other misc travel	439
		Other misc seminars	955
			2,801

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA $4850

(3) Did the nursing home make political contributions or payments to a politica
action organization? YES If YES, have these costs
been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 31,810 Line 10

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ 82,125
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? NO For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? YES Indicate the amount. $ 4,612

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? NO If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? NA
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG Peat Marwick The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? NO If no, please explain. NOT YET AVAILABLE

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.